DHHS Request for Treatment Authorization
of MaineCare Section 65M&N
Child and Family Behavioral Health Treatment or
Community Based Treatment for Children without Permanency

Child's Name: MaineCare#:

Provider MaineCare Billing ID#:

Requested By: Name/Credential/Role _____

Agency: _____ Date of Request (Today's Date): _____

Length of Service Requested (Total # of Calendar Days):_____

Date of First Covered Day Requested: _____

Date of Last Covered Day (LCD) Requested:_____

Est. Avg. Hours of Service per Week: Total:_____ Est. Clinician:_____ Est. BHP:_____

Total Hours for Covered Period Requested: _____

Please check boxes and complete narratives below as appropriate

☐ Continues to meet admission criteria for this level of care
Target Symptoms/Behaviors:

Diagnosis:

Axis I: _____Axis II: _____

Axis III: _____Axis IV:_____

Axis V (CGAS):_____ CAFAS: _____

Medication(s):

Name	Dose	Freq.	Targeted symptoms:
1.			
2.			

Natural Supports available to support child, as identified by parent/guardian(s):

1.

2.

Describe the Nature of Parent/Caregiver Involvement with Specific Treatment Goals and Expected Hours per Week of their Involvement (Required for 65M):

1.

2.

3.

Treatment planning must be individualized, appropriate to the child/adolescent's changing condition, with realistic and specific goals, objectives and measurable outcomes.

List Goals Established and How Outcomes will be Measured:

1.

2.

3.

Describe Discharge Plan and Discharge Criteria (Measurable Outcomes Used to Determine the Client's Readiness for Discharge):

DHHS Use Only:

☐ Approved **Total Hrs:_____ Avg Hrs/Wk:** ____Clinician ____ BHP____**NEW LCD:**_____

☐ Denied Rationale for Denial: _____

_____

_____

_____

_____

☐ Additional Information Needed. **Date request sent**: _____

_____

_____

_____

_____Reviewer Signature _____Date_____